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SC ADAP CENTRAL PHARMACY ANNUAL RECERTIFICATION

Return To:
Central Pharmacy
PO Box 809
State Park, SC 29147
(803) 896-6250 or (800) 856-9954

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE

Date Rec'd: _____ Status: _____

Status/Date: _____

PATIENT INFORMATION: To be completed by Applicant (Please print)

Name: _____
Last First Full Middle Name

Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (____) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon ____ Day ____ Year ____ Sex: _____ Weight: _____ Social Security #: ____/____/____

SOCIAL AND FINANCIAL DATA

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated **Annual** Gross Income
Applicant					

Funds for this program come from Federal HRSA, Title II and State programs and are for low-income persons. This program is the payor of last resort. Persons with Medicaid or Veterans Affairs Benefits cannot qualify for this program.

Current Physician _____ **Current Case Manager** _____

Are you currently approved for Medicaid? ☐ Yes ☐ No **Application pending?** ☐ Yes ☐ No

Persons with insurance coverage may qualify for reimbursement of out-of-pocket/deductible expenses.

Do you have insurance coverage for prescriptions? ☐ Yes ☐ No

CERTIFICATION: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to the ADAP to verify this information, either through written documentation or electronic files. I agree to notify the ADAP of any changes to my income or Medicaid/ insurance status within 30 days. I will inform the ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days.** ***By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I futher authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician or case manager indicated below.***

_____ _____
Applicant's Signature **Date** **Referring Physician or Case Manager** (Print legibly)

_____ _____
Referring Physician or Case Manager Signagure **Date** **Organization** (Print legibly)

To be completed by Physician or Case Manager

The ***most recent*** CD4 (T4) lymphocyte count was _____ on _____ (date drawn). The ***most recent*** viral load result (if available) was _____ on _____ (date drawn).

Have you discussed with this patient the importance of adherence with the medications, especially protease inhibitors?
☐ ***Yes*** ☐ ***No***

Does this patient have a history of (for counseling purposes only): 1) missed appointments? ☐Yes ☐No 2) substance abuse? ☐Yes ☐ No
3) significant medication non-compliance? ☐Yes ☐No 4) mental health issues? ☐Yes ☐No

Central Pharmacy

P. O. Box 809
State Park, SC 29147
803-896-6250 – Columbia
800-856-9954 – Toll Free

Dear Sir or Madam:

This is a new enrollment form. You must fill out and return this form if you want to keep getting your medications from Central Pharmacy. We are trying to cut back on the number of forms you have to fill out for us. So now, you will only have to fill out two forms a year instead of four forms a year.

Please fill in all the blanks and answer all the questions. Your case manager (if you have one) or your doctor (who writes your prescriptions for our program) will have to help you fill out this form. Their signature is required to complete this form.

The **Social and Financial Data** is important and must be completed or the form will be returned to you for completion. Please tell us where you receive the money that you live on and also tell us if the amount that you put down is a weekly, monthly, or yearly amount. **If your income is zero, please put zero in the amount box. Do Not Leave this Box Blank!!!** Please list all of your dependents in this section because **this information may be useful in helping you to continue to qualify for this program.**

You are required to fill out this form once a year in order to stay active on this program and to continue receiving your medications. **Please fill it out and mail it back to us as soon as possible .** If we do not have a current Recertification form for you there could be a delay in receiving medications or you may be removed from the program. We want you to stay healthy so **please call us if you have problems with this form or contact your case manager.**

Please complete and return this form as soon as possible to Central Pharmacy in the Business Reply envelope provided.
No Stamp is needed. It can be placed in any mailbox.
If you have any questions, please call us at **1-800-856-9954 or in Columbia at 896-6250.**
Sincerely,

Melissa Villnow, Director
Don Ray, R. Ph.
Jim Pangle, R. Ph.
Monette Sox, R. Ph.
Missie Fowler, Pharm Tech
Laura Berry, ADAP Enrollment